



Washington State Planning Grant on Access to Health Insurance

HRSA Interim Report

October 29, 2001

Making Health Care Work For Everyone

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WASHINGTON STATE
HRSA STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE
INTERIM REPORT TO THE SECRETARY: OVERVIEW

EXECUTIVE SUMMARY

Washington State received its grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) effective March 2001. States were awarded these grants to assist them in profiling the uninsured and to research innovations in providing access to affordable health insurance coverage and adequate benefits, especially through expanded private/public partnerships.

Two products are required as a condition of the grant: Interim Report due October 2001 and Final Report due March 2002. This report meets the first of those requirements. It is primarily a progress report. We currently are immersed in the process of collecting and analyzing data, and in developing the foundation for determining coverage and access improvement strategies that may have future viability in Washington State.

The following sections include brief descriptions of: (1) the change in Washington's environment post award of the grant, (2) the benefits of receipt of the grant, (3) the balances and trade-offs in the focus of our work, and (4) a high level project overview.

Environment

In the short fifteen months since Washington submitted its grant proposal (July 2000), the context for our work has changed significantly. A State budget surplus has given way to a potential deficit of \$1 billion for the current biennium (July 2001 – June 2003), with an equally fearful outlook for the 03-05 biennium. The spending and revenue limitations under which state government operates, the impacts of a drought and a transportation crisis, plus the passage of initiatives that ear-mark dollars for specific purposes (e.g., teacher pay raises) create unprecedented pressures on the state budget. Add to the picture the following challenges: (1) a general economic downturn including massive aerospace layoffs and uncertainty about consumer confidence (in a state that lives and dies by the sales tax), (2) a growing crisis in our health care delivery system including, for example, hospital workforce shortages and issues around recruitment and retention of physicians in various regions of the state and for certain lines of business, (3) a restructured but untested individual market from which the sickest are screened and referred to a more expensive high risk pool, (4) a public health and safety net system stretched to the maximum, and (5) increasing health care costs hitting both private and public purchasers and consumers.¹ (Although these challenges were already in place prior to September 11, the events and aftermath of that day will surely exacerbate them.)

Grant Benefits

Amid all of this, receipt of the HRSA grant has allowed the State to continue to be an active participant in the search for a more affordable health care system and one that is accessible by all. The grant is supporting work important to short- and long-term planning – work that if it

were happening at all would surely not be happening in the disciplined and rigorous manner allowed by this funding. For example, we are able to (1) provide solid research to help inform policy, program design, and business decisions about health care coverage and access, (2) investigate opportunities for the state to make it easier for private sector and other public sector entities to partner with it, (3) rigorously “mine” our data to better understand populations and systems –much of the data exist but resources are not always available to make maximum use of it, and (4) take advantage of deep and varied outside expertise and perspective.

Balances

There has been no shortage of opinions on where the efforts and resources of the grant should be focused, while remaining true to the proposal on which the grant was awarded. Below are examples of the push-pulls that we continue to balance as our work proceeds.

- ❑ *Expansion or maintenance?* In the short-term (the definition of which is now extending into 2005), the issue for Washington’s public programs is not expansion -- in the best of worlds it is maintenance of past gains and in the worst of worlds it is minimization of deterioration. Nonetheless, ensuring access and coverage remain a state value and priority -- the questions are how, to whom, when, and who will pay. Similar issues extend to all levels of government, as well as to the private sector -- small business employees, individuals buying on their own, people referred to the high risk pool, and early retirees are among those at risk of no longer being able to afford the coverage they have had in the past.
- ❑ *Access to coverage or access to care?* Although access to affordable insurance coverage matters, it is by no means viewed universally as the primary issue. Even in the context of “adequate” benefits, the argument is that coverage does not ensure access to appropriate and effective care -- certainly for those without coverage but also for those with it. The question asked is: What has been achieved if the rate of un-insurance is reduced without addressing “real” access to care?
- ❑ *Incremental or transformative?* There has been much angst over our horizon of focus: targeted, short-term or global, future-shaping; respond to the evolving crises of the day or keep a broader focus. These various perspectives are not necessarily mutually exclusive and we are trying to achieve a balance that treads their common ground. For example, while we focus on doable next steps we put those steps in the context of future changes (e.g., in what populations are we likely to see increasing numbers of uninsured; what if a sea-change occurs among employers and their employees are let loose with defined contribution vouchers to purchase in Washington’s individual market). Admittedly, the reality of “incremental transformation” in the absence of a common vision of the transformed future is a bit of a challenge.

Project Overview²

Washington is taking a very methodical approach to its work and believes that selecting improvement strategies in the absence of data, education, and dialogue will not be successful. Briefly our work consists of the following (plus see Appendix III for Guiding Principles for this project):

- ❑ **Problem Definition** -- Detailed profiles of the uninsured population are matched to detailed profiles of the current coverage and care pathways, followed by a rigorous analysis of the gaps, overlaps and barriers.

- ❑ Strategies Delineation -- Analysis of the strengths and weaknesses of a universe of potential coverage and access options is cross-walked to a similar analysis of parallel strategies historically tried or in place in Washington (including, where appropriate and achievable, quantifiable impacts of strategies on specific uninsured and at-risk populations).
- ❑ Linkage -- Detailed assessment is conducted of the links between identified gaps, overlaps, and barriers to coverage and care (in specific populations and circumstances) and the analysis of improvement strategies (including refinement of strategies based on linkage assessment).
- ❑ Individual Affordability -- Significant energy is devoted to understanding what individuals can afford to pay for coverage and care, compared to the reality of what's available to them. We consider this a "lynchpin" issue for crafting future coverage and access strategies.
- ❑ System Affordability -- Significant effort is focused on administrative simplification strategies and partnerships, including options for reducing the currently complex array of insurance products (while still maintaining choice and variety). Creating a more affordable system via strategies that avoid unnecessary costs, reduce provider administrative burden, and set the stage for effective consumer-driven buying is directly relevant to improving access.
- ❑ Community Partnerships -- Building partnerships with community-based efforts and organizations addressing related issues is also a focus of our work. Mutual understanding of the issues faced, the solutions contemplated, and the flexibilities and accountabilities needed on all sides are part of this work.
- ❑ Education and Input -- Sharing and seeking input into the process and substance of grant activities with a variety of constituent groups (e.g., community and business leaders, policy makers, residents, and industry leaders--providers, purchasers, payers, regulators) is a key goal, as is partnering with others in the state who are interested in both incremental and transformative strategies for improving access for all.

As stated earlier, we are deep into the data collection, analysis, and foundation-building phase of our work. As such our findings on profiles, policy options, lessons learned, and recommendations to States and for Federal action have not yet emerged. Our greatest challenges at this time are not surprising – they are time and attention. Engaging people as we all work around the crises of the day (whether they be health care or otherwise) is not easy or quick. Most eyes are on the current condition of the state budget and the potential for program cuts as well as other impacts on the state's health care delivery and financing systems. In this environment, it is almost beyond the pale to engage anyone in a discussion of expansion of coverage much less universal access. And thus is our challenge -- to think to the future without losing relevance to the present.

In the following sections we add more detail about our progress and process. Each section begins with a summary. Because this is our interim rather than final report, we generally do not have answers to specific questions. In the few cases where information is available, we have bolded the applicable question. (All questions from the report template have been retained – whether answered or not.)

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

Methods: The in-depth profiles of uninsured individuals and families plus the mapping of current pathways for coverage and for access to safety-net-provided care set the stage for detailed analysis of gaps, overlaps and barriers to coverage and care. A special emphasis is being placed on understanding individual affordability. Major data sources consist of existing surveys (population-based and employer-based), a project-specific survey to gather information on benefit designs and costs, administrative data, and focus groups.

Findings: Findings to-date are sketchy and subject to change as analysis continues. Answers to Questions 1.1, 1.2, 1.3, and 1.4 provide a flavor of areas of focus, progress, and early findings (where applicable).

Progress:

- (1) Potential data sources have been compiled, summarized, and analyzed for application to the grant's work (e.g., content analysis, support of local area estimates, and linkage of information across sources). (Information about reasons for differences in estimates across survey sources is already helping to allay suspicions about "the right numbers.")
- (2) Analysis of data-needed versus data-available, and development of strategies for addressing data gaps continues (specifically in relation to matching profile information to possible strategies for coverage and access).
- (3) Specific work focuses on supplementing the Washington State Population Survey (SPS) with the Survey of Income and Program Participation (SIPP); as well as creating baseline information to which routinely collected data (e.g., Medical Expenditure Survey) can be compared in the future. (Given the high cost of primary data collection and the state's desire for on-going monitoring, we have a strong interest in finding creative ways to use existing data that are routinely collected by others.)
- (4) Review of other states' surveys is ongoing, as background for recommended improvements to Washington's biennial household survey.
- (5) First cut profile results are beginning to show (see questions below); more complex, multi-dimensional analyses are underway.
- (6) Coordination among state level experts (demographers and forecasters) and research experts continues as data issues arise (e.g., resolving a problem with the weights associated with children's counts in the Current Population Survey [CPS]).
- (7) See Section 3 for progress on the affordability analysis.

Attached in Appendix III are draft documents related to the analysis of existing data sources: Bibliography for population and employer-based surveys, Overview of population-based surveys, Content analysis of population-based surveys, Overview of employer-based surveys, Content analysis of employer-based surveys, and Data sources for understanding pathways to coverage and care. Also included in Appendix III are Demographics of Washington State's uninsured population (see question 1.2) and the Private payer questionnaire (see question 1.4).

Relationship to Coverage Strategies: Our intent is to align the analyses noted above (i.e., profiles + mapping = gaps, overlaps, barriers analysis) with an equally rigorous analysis of

potential strategies (see Section 4), resulting in a tight link between proposed interventions and targeted populations. We are progressing on this front but have significant work yet to do.

1.1 What is the overall level of uninsurance in your State?

According to the Washington State Population Survey (our baseline source), 8.4 percent of Washingtonians were uninsured in 2000. For children 0-18 years of age, the uninsured rate was 7.2 percent; for adults ages 18-64 the uninsured rate was 10.2 percent. More than three times as many adults as children were uninsured in Washington in 2000.

1.2 What are the characteristics of the uninsured?

Preliminary information (subject to change) regarding the demographics of Washington State's uninsured population is provided in Appendix III. Early results by relevant dimensions (e.g., age, household income)³ can be summarized as follows: Within select

- a. Age groups -- the largest percent of uninsured are 19-24 years of age.
- b. Household income groups -- the largest percent of uninsured are associated with annual household incomes of less than \$14,999 (1999 dollars).
- c. Regions of the state -- the largest percent of uninsured are in rural Eastern Washington.
- d. Race/Ethnicities -- the largest percent of uninsured are identified as American Indian/Alaska Native and Hispanic.

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

We did not decide this a priori; rather we are looking to the data to indicate where and with what populations various interventions might be most effective. We are approaching the profiling task in a variety of ways to determine which information is of most use in matching populations to strategies, e.g., (1) single-variable and multivariate profiling; (2) profiling by demographics, (3) profiling by coverage risk – long-term uninsured, periodic insurance, at high-risk of losing coverage, (4) profiling by work status – worker or live with worker versus not, etc. We are also working on an approach that “backs us into the target populations,” i.e., array the potential universe of coverage and care strategies, map them onto the populations for which they are designed, and assess the degree to which those populations occur in Washington's uninsured. In other words, we are exploring a variety of options for understanding our uninsured population and where targeting of strategies may be most appropriate and effective.

1.4 What is affordable coverage? How much are the uninsured willing to pay?

Although we have no findings to share at this time, affordability of coverage for individuals is a major focus of our work. Our starting point is *The Self-Sufficiency Standard for Washington State*, which assesses by county how much money it takes for families to live without public or private assistance or subsidies.⁴ This information is being combined with data on price sensitivity and with grant-specific survey results on what it actually costs (all out of pocket costs) for various types of coverage in Washington (e.g., individual, small group, and large employer). The survey, Private

Payer Questionnaire, is attached in Appendix III (it is serving multiple purposes, one of which is related to the affordability analysis -- see Section 3).

Results on affordability will have applicability beyond the specifics of this grant period. For example, the Department of Social and Health Services is currently applying for a federal Medicaid waiver to provide flexibility in future design of its program. Design elements such as premium sharing and point-of-service cost sharing levels for certain populations were not directly addressed in the waiver but need to be developed in the future. We are working with the Medicaid program to ensure that our analysis will be applicable to their needs.

We are not prepared to answer the following questions at this time.

- 1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?
- 1.6 Why do uninsured individuals and families disenroll from public programs?
- 1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?
- 1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?
- 1.9 How likely are individuals to be influenced by:
 - Availability of subsidies?:
 - Tax credits or other incentives?:
- 1.10 What other barriers besides affordability prevent the purchase of health insurance?
- 1.11 How are the uninsured getting their medical needs met?
- 1.12 What is a minimum benefit?
- 1.13 How should underinsured be defined? How many of those defined as “insured” are underinsured?

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Methods: In the mid 1990s (approximately 1993-1997) significant work occurred in Washington to understand the profiles of employers who offer and do not offer coverage, and their motivations. To build on that history, we are using focus groups, particularly of small employers. Timing of the focus groups is critical to their effectiveness in guiding our work. That is, we need to build the groups around information – information about the uninsured, individual and market affordability, and analysis of potential options for improving access that may call for employer participation. The hypothesis is that guided discussion in the context of relevant and specific information (compared to a context void of such data) will yield a greater return-on-investment in terms of understanding values, decision-drivers, and areas of ambivalence. Thus we planned that these groups would occur somewhat later in our process—after we have been able to develop the needed information through our profiling and analysis of options-for-access. As this analytic work unfolds, we may also decide that a focused survey of employers would be useful. In that case, we anticipate using the focus groups to help conceptualize and perhaps “pilot test” such a survey. (Clearly, actual fielding of such a survey would occur outside the initial grant-year period.)

Findings: There are no findings to report at this time.

Progress:

Much of this work is dependent upon completion of other work in the grant. However, the following have occurred:

- (1) Existing employer-based surveys have been compiled, summarized, and analyzed for development of baseline information.
- (2) Initial framing of the focus group protocol is occurring; as is preparation for review by the Institutional Review Board (i.e., human subjects review entity).
- (3) See Section 3 for discussion of the Private Payer Questionnaire which is serving multiple purposes, one of which is to understand the scope of products available in the small group market.

Attached in Appendix III are the following: Overview of employer-based surveys, Content analysis of employer-based surveys, Private payer questionnaire.

Relationship to Coverage Strategies: As noted above, we did not start the grant work with pre-selected coverage strategies to pursue. We expect data, education, and input by potentially impacted parties to drive the process of strategy filtering. Understanding the pressures faced by, the trade-offs needed by, and the potential “tipping points” of employers is critical to this process.

We are not prepared to answer the following questions at this time.

- 2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer size (including self-employed):

Industry sector:

Employee income brackets:

Percentage of part-time and seasonal workers:

Geographic location:

Other(s):

For those employers offering coverage, please discuss the following:

Cost of policies:

Level of contribution:

Percentage of employees offered coverage who participate:

- 2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?
- 2.3 What criteria do offering employers use to define benefit and premium participation levels?
- 2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?
- 2.5 What employer and employee groups are most susceptible to crowd-out?
- 2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?:

Individual or employer subsidies?:

Additional tax incentives?:

- 2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Methods: Washington's analysis of the marketplace focuses on four areas: (1) Pathways (options) that people currently have for coverage and access, and where the gaps and overlaps exist; (2) Variety and complexity of product offerings in the market (individual, small group, large group—fully insured and self-insured), and where opportunities exist for complexity reduction; (3) Affordability of coverage for individuals (healthy and sick, various income levels, different geographic regions, several family types, different industries), in light of actual income, income needed to achieve self-sufficiency, and cost of coverage; and, (4) Opportunities for reducing the burden of the administration of health care services, in partnership with the private sector. Secondary data from a variety of existing data sources are being used (e.g., research, industry, regulatory, and administrative databases). In addition, primary data collection is occurring through (a) a marketplace survey (including follow-up focus group and/or interviews) with select insurance carriers and third party administrators and (2) a structured interview protocol administered via telephone with informed experts.

Findings: Data are being collected and analyzed, however, findings are not yet available.

Progress:

- (1) Pathways and Gaps, Overlaps, Barriers: Key indicators and data sources have been identified. Data collection regarding pathways is well in hand; analysis and verification of data are underway. Preliminary mapping of safety net resources has occurred.
- (2) Product Offerings and Costs: The marketplace survey (Private Payer Questionnaire) is in the field. Pre-fielding telephone calls from the Governor's Health Policy Advisor to top officials of major carriers and third party administrators were made to brief them and request cooperation.
- (3) Affordability: The measure of self-sufficiency has been selected. Recommendations regarding sources of data to generate estimates of actual family income are under review. Price sensitivity research is being incorporated into the methodology design.
- (4) Administrative Simplification: Structured interviews with informed experts have been completed and results are under review.

Attached in Appendix III are the following: Data sources for understanding pathways to coverage and care (work-in-progress), Safety net map (work-in-progress), Administrative simplification interview protocol, and Private payer questionnaire (i.e., marketplace survey).

Relationship to Coverage Strategies: Findings from the above will either drive or be directly tied to the analysis of coverage and access strategies.

We are not prepared to answer the following questions at this time.

- 3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?
- 3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

- 3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?
- 3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?
- 3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?
- 3.6 How would universal coverage affect the financial status of health plans and providers?
- 3.7 How did the planning process take safety net providers into account?
- 3.8 How would utilization change with universal coverage?
- 3.9 Did you consider the experience of other States with regard to:
 - Expansions of public coverage?:
 - Public/private partnerships?:
 - Incentives for employers to offer coverage?:
 - Regulation of the marketplace?:

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Methods: There are four separate (but related) efforts that will contribute to developing improvement options or strategies for consideration. Each of these efforts is described below.

- ❑ *Coverage and Access:* This analysis focuses on the strategies traditionally identified as options for improving coverage and access, e.g., employer buy-ins to public programs. Here we are interested in rigorous analysis of the “universe of strategies”, mapped to parallel approaches historically tried and/or currently in place in Washington State, and culminating in analysis of strengths and weaknesses, potential viability for implementation, and estimated impact on specific populations identified in the profile analysis (e.g., number of uninsured in a given population group impacted if this option were implemented.). The database of strategies is being developed via literature reviews, environmental scans of other states’ experiences (state level and otherwise; public and private), and expert opinion. Analysis of options along specified dimensions, estimation of quantitative impacts (where possible), and use of decision criteria for “moving” ideas forward are also part of the methodology. Linkages between strategies and the identified gaps, overlaps and barriers (with each feeding refinement of the other) are paramount.
- ❑ *Administrative Simplification:* This analysis focuses on identifying strategies for simplifying administration of the system. The hypothesis is that simplification of the system will (1) reduce inefficiencies and redundancies, and thus contribute to slowing overall cost growth trends and (2) reduce the “hassle factor” for plans and providers, increasing the likelihood that they will continue to “play” in Washington’s market. A detailed interview inventory is being used with key informants and will provide the baseline for identifying private-public partnerships to cooperatively reduce the administrative costs of health care.
- ❑ *Benefit Distillation:* This research activity is part of simplification but is called out separately. The hypothesis is that there are hundreds of benefit products available across all books of business, that many of these products differ in non-significant ways, and that there may be potential to distill the range of products into a finite set that would maintain consumers’ choices while reducing complexity and cost to the system (and increase consumers’ ability to comparison shop). A marketplace survey of targeted carriers and third party administrators (with follow-up focus groups and/or interviews for in-depth probing) is being used to gather baseline information to test the theory and to inform design of prototypical sets of products. Depending on findings, industry and community interest in pursuing or pilot testing this voluntary approach to simplification will be assessed via focus groups with a variety of potentially impacted parties (e.g., agents and brokers).
- ❑ *Community Initiatives:* This effort focuses on building partnerships with community-based access projects. There are three HRSA Community Access Program (CAP) grantees in Washington State plus numerous other community-based efforts, each focusing on access issues (some looking at systemic change; others focusing on immediate survival). The approach here involves interviews with informed experts; attendance at select community project meetings; and analysis of opportunities for joint pilot testing of ideas (and the concomitant flexibilities and accountabilities needed), for collaborative technical assistance (e.g., data sharing), and for removing barriers to partnership (in either direction).

Findings: There are no findings to report at this time in terms of specific strategies selected or rejected.

Progress:

- (1) General: Guiding principles were developed to ensure understanding of the breadth of options and ideas that should be on the table for exploration and discussion. The principles were initially reviewed by the project's oversight panel and have been posted to our Website for input and feedback by interested parties. Progress on specifics is noted below.
- (2) Coverage and access: Draft dimensions for analyzing strategies have been developed (e.g., who is affected and how, design or implementation considerations, financing, administration, constraints, and potential impacts--coverage impacts, access impacts, other intended impacts, unintended consequences). An initial literature review has been conducted and a preliminary list of the "universe of options" has been compiled and summarized along the draft dimensions. A session to gather expert opinion was held August 2001 at the annual meeting of the National Association of State Health Policy. Models needed to estimate impacts (e.g., number of people potentially impacted if a strategy were implemented) are in development, as are criteria for discriminating among options (i.e., the filters needed to narrow the field).
- (3) Administrative Simplification: See Section 3 on the Health Care Marketplace.
- (4) Benefit Distillation: See Section 3 on the Health Care Marketplace.
- (5) Community Initiatives: "Informed expert" meetings continue to take place (e.g., Washington Health Foundation, Communities that Won't Wait). A telephone interview protocol was developed. Review of other states' exemplary community initiatives is underway.

Attached in Appendix III are the following: Guiding principles, Administrative simplification interview protocol, Private payer questionnaire, and Community initiatives interview protocol.

With the exception of Questions 4.1 and 4.18, we are not prepared to answer the following questions at this time.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

Predating the grant, the Department of Social and Health Services, Medical Assistance Administration, decided to submit a Medicaid Section 1115 demonstration waiver to allow the state more flexibility to administer its Medicaid program. The waiver is scheduled to be filed on October 31, 2001. We have tried to design pieces of our grant work to support future needs of Medicaid should its waiver be approved (e.g., our work on affordability will be of direct assistance).

- 4.2 What is the target eligibility group under the expansion?
- 4.3 How will the program be administered?
- 4.4 How will outreach and enrollment be conducted?
- 4.5 What will the enrollee (and/or employer) premium-sharing requirements be?
- 4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

- 4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)
- 4.8 How will the program be financed?
- 4.9 What strategies to contain costs will be used?
- 4.10 How will services be delivered under the expansion?
- 4.11 What methods for ensuring quality will be used?
- 4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?
- 4.13 How will crowd-out will be avoided and monitored?
- 4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?
- 4.15 How (and how often) will the program be evaluated?
- 4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?
- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.
- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?**

As noted above, we are not yet at this stage of our work. However, given the history of Washington and the current as well as projected state budget deficits, short-term strategies that include any of the following are likely to be considered political non-starters: (1) universal mandates, (2) approaches that increase state expenditures (even with federal match), or (3) approaches that decrease state revenues (e.g., any kind of a B&O tax break to employers who will offer coverage).
- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

SECTION 5. CONSENSUS BUILDING STRATEGY

Overview: The consensus building strategy continues to evolve in response to the changing environment. The pieces of our strategy that have remained constant include: (1) use of a state-agency based oversight panel, the parent of which is the Governor's Sub-cabinet on Health, (2) adherence to a guiding principle that speaks to a low key but broadly inclusive process, and (3) recognition that consensus building on strategies viable in Washington will occur over the long run and through processes fed by the work of the grant but not unique to the grant (e.g., the Legislative process).

The pieces of our strategy that have evolved include: (1) movement away from a large, multi-constituent advisory committee, (2) use of less formal and less structured avenues for building foundations (e.g., smaller meetings involving top executive-branch officials and industry leaders; informal discussions between the Governor's Health Policy Advisor and Legislative leadership; briefings between project staff and legislative staff), (3) identification of partners working on related issues to create synergies and opportunities for both (e.g., linking-up with Community Access Program grantees, partnering with local foundations like the Washington Health Foundation and HumanLinks), (4) taking advantage of existing meeting opportunities ranging from briefings of small groups to a work session at the state's annual Washington Health Legislative conference⁵, (5) creation of a Web-based feedback system accessible by all, and (6) use of ad hoc issue-specific groups rather than standing technical advisory committees.

We anticipate that our process will continue to evolve. The answers below, however, provide a flavor for the process as it now stands.

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

To provide guidance for our work, the grant uses a management oversight panel (MOP), the composition of which is based on the Governor's Sub-cabinet on Health.⁶ MOP members were selected because they represent top aides (e.g., deputies, policy and program advisors, executive directors) of Sub-cabinet members and because they are creative thinkers with significant and varied experience and knowledge with respect to health care in general and Washington history in particular. Agencies represented include the Department of Health (public health agency), Department of Social and Health Services – Medical Assistance Administration (Medicaid agency), Health Care Authority (Public Employees and Basic Health agency), Office of Financial Management (Governor's budget office), Governor's Policy Office (Governor's Health Policy Advisor), Office of the Insurance Commissioner (regulatory agency), and the State Board of Health (public health advisory board).

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Various methods are being used to solicit input and feedback. These include: (1) focus groups and ad hoc issue groups built into the substantive work of the project, (2) collaborations on surveys with various partners (e.g., a community-based effort that is pilot testing a public dialogue approach (with a survey as one component) to understand citizen values around health care issues; a web-based survey of registrants for a highly popular annual health policy-legislative conference), (3) a special work session at the annual health policy-legislative conference, (4) a series of regional meetings to be held around the state and in partnership with others (e.g., State Board of Health; Washington Health Foundation) incorporating the work products of the grant, and (5) informal briefings wherever two or more people gather who will listen to us! Some of these activities are currently occurring, others are in development.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

Four primary efforts occurred early in the project: (1) Pre-dating but in anticipation of receipt of the grant, Governor Gary Locke held a summit of health care leaders to discuss a variety of health care concerns, including issues related to the uninsured; (2) A brochure describing the goals and process of the grant was developed, used at various meetings, and posted to our website; (3) A letter was sent from the Governor's Health Policy Advisor to over 100 constituent groups/individuals and to Legislative health care leadership to alert them to the work of the grant and invite their involvement; and (4) A grant-specific website was developed.

The website was initially designed to provide easy access by potential bidders to our Request For Proposals for consultant assistance, rather than as a site to educate, build awareness, and provide input and feedback into our work. The site was recently redesigned with these latter purposes in mind. We launched our first "E-mail Alert" to an interested-party list of over 300 people, notifying them of new items posted to the website and our interest in their feedback. We will be using the website as a primary tool for broad and inclusive access to our work

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

Please see the Executive Summary for this response.

Attached in Appendix III are the following: Guiding principles, Website home page, and Overview of strategy for seeking input and feedback.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

With the exception of Question 6.8, we are not yet ready to answer the following questions.

- 6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?
- 6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?
- 6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?
- 6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?
- 6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?
- 6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?
- 6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

Although it is premature to identify key lessons and recommendations to states, the following are some initial thoughts:

- a. **One year is not enough**, especially if there is a high need or desire to inform discussions and build consensus based on state-specific information. Although it is too early to know for certain, there is a growing likelihood that some of the work we want to do and feel is critical to success will have to occur beyond the initial grant year.
- b. **Timing is critical**, especially in terms of the need to coordinate with “defining” events. Even though this project and improving access are not solely about state programs and government response, those are critical. For example, in Washington we are trying to be mindful of our Legislative session and the biennial budget building cycle. In Spring 2002, executive branch agencies begin their budget building process during which priorities and resources are aligned for the 03-05 biennium. Work during the following Legislative session, beginning January 2003, determines the final biennial budget (and thus the priorities for state dollars).

- c. **Partner with others** who are working on similar and related issues. Synergies, economies of scale regarding effort, understanding differences in foci and desired outcomes, creating an early basis for future consensus building, and cross-pollination of ideas are among some of the advantages.
- d. **Be disciplined and flexible.** Be disciplined and focused in conducting the substance the work (e.g., data collection and analysis) but let the process of engaging others be flexible and evolve as information and environment change.
- e. **Develop guiding principles** as a means to communicate and educate, set expectations, and jump start discussions on the focus of the work. Different sets of principles, specific to various components of the project, may be helpful. For example, we developed one set of principles for our “approach to the work of the grant” and another set for signaling the breadth of our interest in options for addressing coverage and access.
- f. **Build consultants into initial proposals** if their assistance is anticipated. There is precious little time in a one-year project, much of which can be eaten up by a 3-4 month competitive bid process (depending on state rules).

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

As above, recommendations to the federal government are premature given the interim status of this report. However, the following bear mentioning at this point:

1. **Funding for planning, policy development, and pilot testing.** Given growing state budget deficits, states may need to look more than ever to the federal government and/or foundations to support certain activities (at least in the short run of the next 3-5 years). These activities, although often viewed as critical by states, frequently must (and should) take a back seat to meeting the direct and “of-the-moment” needs of populations being served. What is lost, however, is also great – it is the ability to put in motion today what is needed to prevent similar crises tomorrow. The same points can be made, perhaps even more strongly, for community-based programs.
2. **Collaboration among state and community grant efforts.** As future state-planning and community-implementation grants are contemplated, incentives by the grantors to encourage close collaboration may be worth considering.
3. **Flexibility.** As states examine the range of coverage approaches that most efficiently and effectively address their needs, they will be looking to the federal government for streamlined administrative requirements and maximum flexibility (i.e., waivers) to allow development of new options and tools needed to manage their programs.

- 7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?
- 7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?
- 7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?
- 7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

APPENDIX I: BASELINE INFORMATION

Where applicable to our work, the following requested baseline information will be provided in the Final Report.

Population:

Number and percentage of uninsured (current and trend):

Average age of population:

Percent of population living in poverty (<100% FPL):

Primary industries:

Number and percent of employers offering coverage:

Number and percent of self-insured firms:

Payer mix:

Provider competition:

Insurance market reforms:

Eligibility for existing coverage programs (Medicaid/SCHIP/other):

Use of Federal waivers:

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Most of the information regarding our research work will be posted to our website, <http://www.ofm.wa.gov/accesshealth/accesshealth.htm>, as it becomes available.

APPENDIX III: REFERENCED ATTACHMENTS

1. Bibliography for population and employer-based surveys
2. Overview of population-based surveys
3. Content analysis of population-based surveys
4. Overview of employer-based surveys
5. Content analysis of employer-based surveys
6. Data sources for understanding pathways to coverage and care
 - a. Overview of administrative data sources
 - b. Overview of safety net data sources
 - c. Overview of other data sources
7. Demographics of Washington State's uninsured population
8. Private payer questionnaire (i.e., marketplace survey)
9. Safety net map
10. Administrative simplification interview protocol
11. Community initiatives interview protocol
12. Guiding principles
13. Overview of strategy for seeking input and feedback
14. State Planning Grant website (<http://www.ofm.wa.gov/accesshealth/accesshealth.htm>)

¹ The winds of change began to significantly appear during the 2001 Legislative session. For example, budget pressures resulted in reducing the funded spaces for Basic Health (BH) (the state-only subsidized program for the working poor) from 133,000 to 125,000. There is now a waiting list of approximately 5,000 individuals. (There is also an initiative on Washington's November ballot to increase the tax on cigarettes and tobacco products in order to [among other things] fund additional spaces in BH.)

² To assist in completing grant activities, a consortium of consultants was awarded a contract in June 2001. Members of the consortium are: University of Washington, Health Policy Analysis Program; University of Washington, Department of Family Medicine; Rutgers University, Center for State Health Policy; The RAND Corporation; Foundation for Health Care Quality; and William M. Mercer, Inc.

³ These results differ from those that would be obtained if the analysis focused on the distribution of uninsured. See Appendix III, Demographics of Washington State's Uninsured Population--Race and Ethnicity of Uninsured Adults, for an example of the distinction. That is: Using the uninsured population as the base, only 6.0 percent of uninsured are American Indian/Alaska Native. In contrast, within the American Indian / Alaska Native group the rate of uninsured is 28.7 percent.

⁴ Diana Pearce, Ph.D. with Jennifer Brooks, *The Self-Sufficiency Standard for Washington State*, Prepared for the Washington Association of Churches, the Washington Living Wage Movement and the Washington Self-Sufficiency Standard Committee, September 2001.

⁵ The theme of the conference is civic engagement and health system change. Our "breakout" session is titled The State Planning Grant on Access: Can We Talk?

⁶ The Governor's Sub-cabinet on Health was created by Governor Gary Locke for the following purposes: (1) to develop and coordinate state health care policy and purchasing strategies, (2) as a forum for the exchange of information, and (3) as a forum to coordinate statewide efforts to provide appropriate, available, cost effective, quality health care and public health services to the citizens of Washington.